DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAID PURCHASING ADMINISTRATION
Olympia, Washington

To:	Ambulatory Surgery Centers Managed Care Organizations	**Memo #: 10-85** **Issued: December 30, 2010**
From:	Doug Porter, Administrator and Medicaid Director Health Care Authority/Medicaid Purchasing Administration	**For information, contact:** 1-800-562-3022, or go to: http://hrsa.dshs.wa.gov/contact/default.aspx

Subject: Ambulatory Surgery Centers (ASC): 2011 Fee Schedule and Policy Updates

Effective for dates of service on and after January 1, 2011, unless otherwise specified, the Department of Social and Health Services (the Department) will:

- Revise the definition for an Ambulatory Surgical Center (ASC);
- Update the *ASC Fee Schedule* with procedure code revisions;
- Add Year 2011 Current Procedural Terminology (CPT®) codes and Year 2011 Healthcare Common Procedural Coding System (HCPCS) codes to the *ASC Fee Schedule*;
- Update the *ASC Fee Schedule* with new authorization codes with budget reduction related changes;
- Make changes to the *Dental Program for Clients 21 and Older* that affect ASCs; and
- Implement new authorization codes.

Overview

All policies previously published remain the same unless specifically identified as changed in this memo.

The Department has not implemented the Centers for Medicare and Medicaid Services (CMS) ASC Outpatient Prospective Payment System (OPPS).

The Department will continue to cover only the following services in an ASC:

- Services that cannot safely and routinely be performed in a physician's office; and
- Services that can safely be performed outside of the hospital setting.

The Department continues to use the Year 2007 Medicare Fee Schedule Database (MFSDB) ASC groups for procedure codes allowed by the Department in 2007, and has assigned ASC groups to procedure codes for subsequent years, including the new codes for 2011. The Department does not reimburse separately for procedures which are bundled. Many covered implantable medical devices are not bundled for ASCs. The Department pays for covered implantable medical devices separately if the claim includes supporting documentation.

The Year 2011 *ASC Fee Schedule* reflects the changes included in this memo.

Bill the Department your usual and customary charge.

The Department requires that you must bill one claim for all services per client, per date of service.

Any corrections to a final paid or partially paid bill must be billed as an adjustment.

Revision of Ambulatory Surgery Centers Definition

Effective January 1, 2011, the Department will define an Ambulatory Surgery Center (ASC) as follows:

> **Ambulatory Surgery Center (ASC)** - Any distinct entity certified by Medicare as an ASC that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

ASC Fee Schedule Updates

Effective for dates of service on and after January 1, 2011, the Department will incorporate the Year 2011 CPT and HCPCS procedure code updates into the ASC Fee Schedule.

> **Note:** Do not use CDT, CPT and HCPCS codes that are deleted in the "*Year 2011 CPT*" book, "*Year 2011 CDT*" book, or the "*Year 2011 HCPCS*" book for dates of service after December 31, 2010.

You may view the Department/MPA *ASC Fee Schedules* online at: http://hrsa.dshs.wa.gov/RBRVS/Index.html.

CPT® codes and descriptions only are copyright 2010 American Medical Association.

Fee Schedule Additions

Effective for dates of service on and after January 1, 2011, the Department will add the following CPT and HCPCS codes to the ASC Fee Schedule:

Procedure Code	Brief Description	Group	Authorization
0238T	Trluml perip athrc iliac art	3	
0249T	Ligation hemorrhoid w/us	#	
0250T	Insert bronchial valve	#	
0251T	Remov bronchial valve addl	#	
0252T	Bronchscpc rmvl bronch valve	#	
0253T	Insert aqueous drain device	#	
11045	Deb subq tissue add-on	2	
11046	Deb musc/fascia add-on	2	
11047	Deb bone add-on	2	
29914	Hip arthro w/femoroplasty	3	
29915	Hip arthro acetabuloplasty	3	
29916	Hip arthro w/labral repair	3	
31295	Sinus endo w/balloon dil	3	
31296	Sinus endo w/balloon dil	3	
31297	Sinus endo w/balloon dil	3	
31634	Bronch w/balloon occlusion	2	
37220	Iliac revasc	4	
37221	Iliac revasc w/stent	4	
37222	Iliac revasc add-on	4	
37223	Iliac revasc w/stent add-on	4	
43753	Tx gastro intub w/asp	1	
43754	Dx gastr intub w/asp spec	1	
43755	Dx gastr intub w/asp specs	1	
43756	Dx duod intub w/asp spec	1	
43757	Dx duod intub w/asp specs	1	
49327	Lap ins device for rt	5	
49418	Insert tun ip cath perc	3	
53860	Transurethral rf treatment	#	
57156	Ins vag brachytx device	1	
58565	Hysteroscopy, sterilization	7	EPA
64566	Neuroeltd stim post tibial	#	
64568	Inc for vagus n elect impl	9	PA
64569	Revise/repl vagus n eltrd	2	PA
64570	Remove vagus n eltrd	2	PA

CPT® codes and descriptions only are copyright 2010 American Medical Association.

Procedure Code	Brief Description	Group	Authorization
65778	Cover eye w/membrane	1	
65779	Cover eye w/membrane stent	1	
66174	Translum dil eye canal	#	
66175	Trnslum dil eye canal w/stnt	#	

Legend:

EPA= Expedited Prior Authorization
PA = Prior authorization.
 # = Not Covered

Coverage Table Updates

For dates of service on and after January 1, 2011, the Department will ***add*** the following procedure code to the ASC coverage table:

Procedure Code	Brief Description	Group	Authorization
58565	Hysteroscopy, sterilization	7	EPA

Prior Authorization Changes

For dates of service on and after January 1, 2011, the Department will require prior authorization for the following procedure code:

Procedure Code	Brief Description	Group	Authorization
63655	Implant neuroelectrodes	3	PA

CPT® codes and descriptions only are copyright 2010 American Medical Association.

Effective for dates of service on and after January 1, 2011, the Department is using the following new codes in the authorization column of the fee schedule to indicate the Department's changes in program coverage and limitations. These are not authorization codes and do not need to be placed on a claim.

Authorization Code	Description
CO	Covered only in benefit packages for children 20 years of age and younger and clients served by the Division of Developmental Disabilities.
COME	Covered only in benefit packages for children 20 years of age and younger and clients served by the Division of Developmental Disabilities unless the client is eligible for coverage with the emergency oral healthcare benefit package.

Oral Health for Clients 21 Years of Age and Older Changes

(Previously *Dental Program for Clients 21 Years of Age and Older*)

Washington State is in the midst of a serious economic downturn and faces another critical shortfall in state revenue as we approach the new biennium. Governor Gregoire is addressing that deficit, working with legislative leaders to implement budget cuts needed to balance the state's revenue and expenditures. On December 11, the Legislature passed HR3225 ("Operating Budget – Second Special Session Amendments"), which altered the adult dental benefit in Medicaid.

Effective January 1, 2011, Medicaid will eliminate the optional dental services from all benefit packages for clients 21 years of age and older as a consequence of that legislation. **Exceptions:** First, clients served by the Division of Developmental Disabilities retain current level of coverage under a new dental program. All current policy and requirements remain in effect for these clients. Second, all clients will continue to be eligible for the emergency treatment of pain, infection, or trauma in the mouth or jaw, under the conditions specified in the Physician-Related Services/Healthcare Professional Services Billing Instructions. For more information about these changes, refer to # memo 10-86.

How Can I Get the Department/MPA Provider Documents?

To download and print the Department/MPA provider numbered memos and billing instructions, go to the Department/MPA website at: http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).

CPT® codes and descriptions only are copyright 2010 American Medical Association.